BlueCross BlueShield of Kansas City
An Independent Licensee of the Blue Cross and Blue Shield Association

City of Kansas City, Missouri Health Care Trust
Health Benefit Plan Summary

Effective Date: 5/1/14

This Benefit Summary provides only a highlight of the services covered by Blue Cross and Blue Shield of Kansas City. ***www.bluekc.com***

	Blue-Care (Health Maintenance Organization - HMO) BASE PLAN	**Blue-Care (Health Maintenance Organization - HMO) MID-LEVEL PLAN**	**Blue-Care (Health Maintenance Organization - HMO) PREMIUM PLAN**	**Preferred-Care Blue (Preferred Provider Organization - PPO)**
Plan Description *(Visit our website at www.bluekc.com to receive a complete listing of network hospitals and physicians)*	Members choose a primary care physician. Members may self-refer to physician specialists in the Blue-Care network. Urgent care and an exclusive network of specialists are also covered; **other services must be ordered by an HMO Physician.**	Members choose a primary care physician. Members may self-refer to physician specialists in the Blue-Care network. Urgent care and an exclusive network of specialists are also covered; **other services must be ordered by an HMO Physician.**	Members choose a primary care physician. Members may self-refer to physician specialists in the Blue-Care network. Urgent care and an exclusive network of specialists are also covered; **other services must be ordered by an HMO Physician.**	Members can receive services from any hospital or physician but receive greater benefits when they use the Preferred-Care Blue network.
Deductible	N/A	N/A	N/A	$500 per individual/ $1,000 per family
Coinsurance *(1)*	N/A	N/A	N/A	Network: 90% / Non-network: 70%
Out-of-Pocket Maximum *(2)*	Inpatient/Outpatient services limited to 5 copays per member per calendar year.	Inpatient/Outpatient services limited to 5 copays per member per calendar year.	Inpatient/Outpatient services limited to 5 copays per member per calendar year.	Network: $2,500 individual/$5,000 family; Non-network: $5,000 individual/$10,000 family
Physician Office Visits	PCP office visits: $30 copay Specialists: $60 copay	PCP office visits: $20 copay Specialists: $40 copay	PCP office visits: $15 copay Specialists: $30 copay	Network: $20 copay *(3)* Non-network: Deductible then coinsurance
Lab Performed in Physician's Office/Independent Lab	No copay	No Copay	No Copay	Network: No copay Non-network: Deductible then coinsurance
Lab Performed in Hospital/Outpatient Facility	No copay	No Copay	No Copay	Network: Deductible then coinsurance Non-network: Deductible then coinsurance
X-ray and Other Radiology Procedures	No copay	No Copay	No Copay	Network: Deductible then coinsurance *(4)* Non-network: Deductible then coinsurance
Routine Preventive Care *(Contract lists covered services)*	100%	100%	100%	Network: 100% Related Office Visit: 100% Non-network: Deductible then coinsurance Unlimited Calendar year maximum
Mammograms, Pap Smears and PSA tests	100%	100%	100%	Network: 100% Related Office Visit: 100% Non-network: Deductible then coinsurance Unlimited Calendar year maximum
Routine Vision Care	$10 copay *(5)*	$10 copay *(5)*	$10 copay *(5)*	No Benefit
Inpatient Hospital Services/Outpatient Surgery*	$500 copay per day up to $2,500 per calendar year	$300 copay per day up to $1,500 per calendar year	$100 copay per day up to $500 per calendar year	Deductible then coinsurance *(4)*

[1]Portion of covered charges paid by BCBSKC after you satisfy your deductible and required copayments.
[2]Total of deductible and coinsurance members pay each year toward covered charges before BCBSKC pays 100% of benefits.
[3]Other services/procedures not specified on this benefit schedule that are performed in a physician's office are subject to the Network Deductible and Coinsurance level.
[4]Diagnostic services performed at a Non-Participating Imaging Center inside Our Service Area are limited to $200 per day. Inpatient hospital services in a Non-Participating Hospital inside our service area are limited to a $200 maximum per day. Outpatient services at a Non-Participating Provider Hospital or at a Non-Participating Provider outpatient facility (including an ambulatory surgical center) inside our service area are limited to $200 per day.
[5]Vision Care: You may receive one vision exam per year (PCP referral not required).
[6]Other services/procedures that are performed by an urgent care provider are subject to the Network Deductible and Coinsurance level

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MRI, MRA, CT and PET scans performed in a Physician's Office, Imaging Center or Other Outpatient Setting (including a hospital)	$150 copay Only one copay will apply for each provider on a specified date of service even if multiple scans are performed			Deductible then coinsurance
Emergency Room *(Copay waived if admitted to a hospital)*	$175 copay			$175 copay then network Deductible & network coinsurance
Urgent Care	$50 copay if services are received in an **urgent care center**.	$30 copay if services are received in an **urgent care center**.	$20 copay if services are received in an **urgent care center**.	Network: $20 copay (office visit and lab only) *(6)* Non-network: Deductible then coinsurance
Ambulance	No copay Ground ambulance limited to $500 benefit maximum per use.	No copay Ground ambulance limited to $500 benefit maximum per use.	No copay Ground ambulance limited to $500 benefit maximum per use.	Deductible then 90% Ground ambulance limited to $500 benefit maximum per use.
Electronic Physician Visit (e-visit)	PCP: $10 copay Specialist: $10 copay	PCP: $10 copay Specialist: $10 copay	PCP: $10 copay Specialist: $10 copay	Network (Providers in our Service Area): $10 copay Non-network: No Benefit
Durable Medical Equipment*	No copay	No copay	No copay	Deductible then coinsurance
Allergy Testing, Treatment, Injections	No copay for injections; $100 copay for testing	No copay for injections; $100 copay for testing	No copay for injections; $100 copay for testing	Deductible then coinsurance
Home Health Services*	No copay 60 visit calendar year maximum	No copay 60 visit calendar year maximum	No copay 60 visit calendar year maximum	Deductible then coinsurance 60 visit calendar year maximum
Skilled Nursing*	No copay 30 day calendar year maximum	No copay 30 day calendar year maximum	No copay 30 day calendar year maximum	Deductible then coinsurance 30 day calendar year maximum
Outpatient Therapy (Speech, Hearing, Physical and Occupational)*	No copay Physical and Occupational: 40 visit calendar year maximum. Speech and Hearing: 20 visit calendar year maximum	No copay Physical and Occupational: 40 visit calendar year maximum. Speech and Hearing: 20 visit calendar year maximum	No copay Physical and Occupational: 40 visit calendar year maximum. Speech and Hearing: 20 visit calendar year maximum	Deductible then coinsurance Physical and Occupational: 40 visit calendar year maximum. Speech and Hearing: 20 visit calendar year maximum
Chiropractic Services*	No copay	No copay	No copay	Network: $20 copay (office visit only) Non-network: Deductible then 70%
Inpatient Mental Illness & Substance Abuse*	$500 copay per day up to $2,500 per calendar year	$300 copay per day up to $1,500 per calendar year	$100 copay per day up to $500 per calendar year	Deductible then coinsurance
Outpatient Mental Illness & Substance Abuse*	$30 copay	$20 copay	$15 copay	Network Office Visit: $20 Copay Therapy: Deductible then coinsurance Non-network: Deductible then coinsurance
Inpatient Hospice Facility*	$250 copay per day up to $2,500 per calendar year Copayments paid for Inpatient Hospice apply to the maximum amount you pay for inpatient services and outpatient surgery in any calendar year 14 day lifetime maximum	$150 copay per day up to $1,500 per calendar year Copayments paid for Inpatient Hospice apply to the maximum amount you pay for inpatient services and outpatient surgery in any calendar year 14 day lifetime maximum	$50 copay per day up to $500 per calendar year Copayments paid for Inpatient Hospice apply to the maximum amount you pay for inpatient services and outpatient surgery in any calendar year 14 day lifetime maximum	Deductible then coinsurance 14 day lifetime maximum

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Organ Transplant*	Applicable copays Unlimited lifetime maximum	Applicable copays Unlimited lifetime maximum	Applicable copays Unlimited lifetime maximum	Deductible then coinsurance Unlimited lifetime maximum
Prescription Drugs *(Includes contraceptives -- orals, injectables*, implants and devices and some Over-the-Counter drugs are also covered at a $1.00 Copay.* ***Please see list of covered Over-the-Counter drugs.)***	**BCBSKC Rx Network** $12 copay for Type 1 drug; $35 copay for Type 2 brand drug; $60 copay for Type 3 brand drug	**BCBSKC Rx Network** $12 copay for Type 1 drug; $35 copay for Type 2 brand drug; $60 copay for Type 3 brand drug	**BCBSKC Rx Network** $12 copay for Type 1 drug; $35 copay for Type 2 brand drug; $60 copay for Type 3 brand drug	**BCBSKC Rx Network** $12 copay for Type 1 drug; $35 copay for Type 2 brand drug; $60 copay for Type 3 brand drug Non-network: 50% after copay
Prescription Drugs: **Mail order drug program –** **102 day supply**	$24 copay for Type 1 drug; $70 copay for Type 2 brand drug; $120 copay for Type 3 brand drug	$24 copay for Type 1 drug; $70 copay for Type 2 brand drug; $120 copay for Type 3 brand drug	$24 copay for Type 1 drug; $70 copay for Type 2 brand drug; $120 copay for Type 3 brand drug	$24 copay for Type 1 drug; $70 copay for Type 2 brand drug; $120 copay for Type 3 brand drug
Lifetime Maximum	Unlimited			
Notice of Religious Rights	Your coverage does include elective pregnancy termination coverage. An enrollee who is a member of a group health plan with coverage for elective abortions has the right to exclude and not pay for coverage for elective abortions if such coverage is contrary to his or her moral, ethical, or religious beliefs. Please call Customer Service to exclude coverage.			
Dependent Coverage *Dependent daughters covered for maternity.*	End of calendar year the children reach age 26 or the month they are no longer an eligible dependent, whichever is first.			
Prior Authorization Penalty *(Prior Authorization is required for selected services. See your certificate for a listing of services requiring Prior Authorization).*	Prior authorization is the responsibility of the network provider.			You are responsible for prior authorization for services received from non-network and out-of-area providers. If prior authorization is not obtained for services which require prior authorization, you are responsible for the cost of the services.
Pre-existing Exclusion Period	No longer applies due to ACA regulations effective 5/1/14.			
Portability	No longer applies due to ACA regulations effective 5/1/14.			
Late Enrollees	For employees or dependents applying after the eligibility period and not within a special enrollment period, coverage will become effective only on the group's anniversary date.			
Detailed Benefit Information Exclusions and Limitations	Call a Customer Service Representative or consult your booklet/certificate. The certificate will govern in all cases.			
Customer Service	**816-395-2969; 800-422-7318 or *www.bluekc.com***			

*Prior Authorization will be required for elective inpatient admissions, durable medical equipment (DME), infusion therapy and self-injectables, organ and tissue transplants, some outpatient surgeries and services, hi-tech scans, hearing therapy prosthetics and appliances, mental health and chemical dependency, some outpatient prescriptions, skilled nursing facility, dental implants and bone grafts, and (for PPO only) chiropractic services received from a non-network chiropractor. This list of services is subject to change. Please refer to your contract for the current list of services, which require Prior Authorization.

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